VERMONT AGENCY OF HUMAN SERVICES DEPARTMENT OF HEALTH CERTIFICATE OF APPROVAL APPLICATION/ PROPOSAL FOR VSH FUTURES CRISIS STABILIZATION/ INPATIENT DIVERSION BEDS

Applicant:	Northeast Kingdom Human Services, Inc.
Project Title:	Northeast Kingdom Crisis Bed and Hospital Diversion Project
Principal Contact:	Cathy W. Rousse, LICSW
Address:	560 Railroad Street P.O. Box 368 St. Johnsbury, VT 05819-0368
Telephone:	802-748-3181
Fax:	802-748-0704

Project Type & Amount

☐ Capital expenditure exceeding $1,500,000 for construction, development, purchase or long-term lease of property or existing structure

☐ Purchase of a technology, technology upgrade, other equipment or a renovation with a cost exceeding $1,000,000

X The offering of a health care service having a projected annual operating expense that exceeds $500,000 for either of the next two budgeted fiscal years if the service was not offered by the health care facility within the previous three fiscal years.

A. Proposed Capital Expenditure (Total Table 1) $ ____- 0 -_____

B. Proposed Lease Amount (payment times term) $ __24,00 per year____ .I certify to the best of my knowledge and belief, that the information in this application is true and correct and that this application has been duly authorized by the governing body of the applicant.

CERTIFYING OFFICIAL: Eric Grims, Executive Director
(Name & Title)

SIGNATURE: _____**Eric T. Grims**_____

DATE: 02/07/07

Application / Proposal Narrative

1. Required Program Elements for Crisis Stabilization / Inpatient Diversion Bed Capacity.

1.1 The service or programs proposed by the applicant for this RFP will be completely voluntary. How will prospective clients be encouraged to use the program?

The proposed community based crisis program will admit patients only on a voluntary basis. Currently persons who are screened by our emergency team and require hospitalization must travel significant distances to receive the psychiatric interventions necessary to stabilize their conditions and to secure safety for them and the communities where they live. During screening, when clients learn of the limited resources available to them for local short term crisis intervention, most of the clients are frustrated as well as anxious, because they are afraid that they will have to be sent to a hospital in another county or even several counties away, often for an undisclosed amount of time. We believe the benefits of a local crisis bed (i.e., not a locked unit) with continued and coordinated care from local providers, with maintained community and family supports during the duration of the crisis will help many prospective clients recognize the value of accepting the help this program will provide to them. We foresee this program as being multi-functional based on bed availability. At times providing a brief safe haven for some individuals, allowing for triage and observation and at other times acting as a step down transition bed from a more intense inpatient stay, affording each person the opportunity to re-acclimate back into her/his community living situation. Full disclosure and engagement capabilities will be the key factors influencing client participation in this program. Recognition of our program by area providers who support referrals to this program will also help to positively influence utilization by prospective clients.

1.2 How will the new crisis bed capacities proposed function as part of the larger care management system and system of care?

As soon as we are awarded the contract, we at NKHS will provide descriptions of our program, referral procedures, admission and discharge criteria, care management and recovery principles as well as the perceived program strengths and weaknesses to local healthcare providers and providers in the larger system of care, which includes the current inpatient psychiatric treatment providers and all resources encompassed by the designated agency system. We intend to adopt wherever possible common clinical protocols (e.g., medication management, clinical practice guidelines and the LOCUS [Level of Care Utilization System] scales) for all admissions, discharges and risk assessment. We will work with the current care management system to assure that there is access to services and that necessary coordination of services among all facilities in the system of care occurs in a timely manner. As stated above, this will be a multi-functional program, insuring maximum utilization opportunities. From crisis stabilization to hospital step down care, we can be an integral part of the state wide system of care.

1.3 Who will be served in the program? How will the applicant assure that the program is available to respond to the general needs of the adult acute mental health care system and is available to individuals 18 years or older, not limited to CRT consumers?

This program is intended to provide a variety of hospital diversion/crisis stabilization services to all adult Vermonters, 18 years old and over who meet the mental health criteria and who accept admission to our program pending bed availability. Though we do anticipate significant use of this program by CRT clients, as the Crisis Bed Work Group survey showed

that in the Northeast Kingdom we could have diverted 27 non-CRT adults out of 52 adults from hospital admissions. With only a two bed program being proposed now due to funding limitations, we will have to manage our two bed capacity carefully to insure community access for all clients especially non-CRT clients. In this community, we have built in other wrap around services for our CRT population, including Short Term Beds (STB) and "respite" options in time of crisis. It is often the non-CRT client, who has a psychiatric crisis and/ or other mental health crisis for the first time that has the greatest impact on the referral of clients through our emergency department to inpatient stays.

1.**4 How will the program provide:**

a) Daily medical oversight

The proposed crisis bed program will be a part of our Emergency Services Department, which includes nursing and nursing oversight that will be provided daily. However medical oversight will be limited to medication monitoring, and the review of vital signs (e.g., blood pressure, temperature, pulse, and respiration) as well as general health assessments that will be used to refer clients to higher levels of care or other health maintenance providers when indicated. The majority of program referrals will come through our usual screening procedures and the prospective clients will be medically cleared at the hospital prior to the emergency screener's patient interview. It is highly probable that well known CRT applicants considered for admission may circumvent the medical clearance procedure when there is no evidence of medical, addictive, or psychiatric co-morbidity unless parameters have been established to maintain the client with known co-morbidities within the scope of the program.

b) Daily access to a psychiatrist

The crisis bed program will include a psychiatrist who will make daily rounds Monday through Friday with weekend phone consultation. Included among the psychiatrist's duties will be reviewing current medication regiments for effectiveness, ameliorating complications with side effects, checking patient compliance with treatment and participating as part of the "Crisis Bed" clinical team's case review process. After hours and weekend emergencies will be handled through our regular on call psychiatry schedule. The psychiatry team will consist of both medical doctors and nurse practitioners. They will act as community consultants and work with other providers when necessary to advocate for appropriate levels of care.

c) Peer services and support

Our CRT program has been developing a peer supported recovery component with several members now working as NKHS employees. This crisis/diversion program will welcome the peer services and support from our CRT program. We will also coordinate trainings and the volunteer process with Vermont Psychiatric Survivors and our local Recovery Center. When appropriate, clients residing in the "crisis unit" may attend off sight local peer run support groups when they are accompanied by staff.

d) Adequate staffing

The staffing profile will consists of round the clock staff, 24/7, with a staff to client ratio of 1 to 2. In addition to the direct service staff a program director will insure clinical oversight, manage the policies and procedures involved in admitting, program function, and discharge planning of all consumers. The proposed crisis bed program will be included in our Emergency Services Department, which will further enhance the staffing capability of the program with our experienced QMHP (Qualified Mental Health Professional) screeners. We will enhance our psychiatric service capability at NKHS by working collaboratively within

our own integrated departments to enhance our Crisis Bed Program capacity. When CRT clients are being served, the client's case manager and/or PACT (Program of Assertive Community Treatment) team members will be directly involved in the programming at the unit. NKHS has an active internship program that includes for example BA degree candidates, master's level clinicians, and advanced practice registered nurses. These people will participate in a rotation in our crisis unit as part of their internship curriculum. We believe this will enhance the internship training experiences as well provide NKHS with an additional psychiatric service capability. We will utilize and continue to develop our cadre emergency list of qualified staff to call upon when 1-on-1 or 2-on-1 emergency situations are anticipated.

1.5 What specific treatment and support modalities will be offered and how do these relate to the clinical mission of crisis stabilization and inpatient diversion?

The clinical mission of the proposed unit is to provide a safe, empathic environment for people in psychiatric crisis or stepping down from a higher level of care. A place where they can be clinically assessed and offered appropriate interventions, which will allow them to remain in their communities and avoid short or long-term hospitalization. All services provided will always emphasize hope, possibility and personal independence.

The program will have a focus on minimizing the risk factors and supporting the protective factors unique to each individual client's needs. Day and evening staff will provide recovery oriented services in the form of group recovery activities in a milieu that promotes wellness, empowerment, a sense of community, personal responsibility, self-esteem and hope. Activities will be client centered and focused on where the client is in her/his treatment process (stages of change). People admitted to the program will be able to participate in on-going scheduled activities such as groups, psychiatry appointments or CRT related activities after initial stabilization and if participation is clinically appropriate. Staff clinicians will provide brief solution focused counseling with an emphasis on the each client's individual strengths.

Services will include comprehensive screening and service coordination among service providers before, during and after discharge from the program. These services will help maintain continuity of treatment goals and objectives. We also anticipate providing multi-disciplinary supports such as crisis intervention, behavior modification, and social and life skills training, which include topics like understanding psychiatric disorders, self empowerment, and medication management.

Peers will be able to offer support and recovery resources specific to individual needs, and the location of the client's home, with an emphasis on socialization, daily skill development, crisis support and wellness. If a client does not already have a WRAP (Wellness Recovery Action Plan), staff will work with the client to begin the process of developing a WRAP plan.

1.6 How will the proposed crisis bed program provide as much capacity as possible within appropriated resources?

The integrated design of the proposed crisis program lends itself well to full utilization of resources. The Emergency Services Department will be partially housed in the crisis unit facility. The Emergency Services Department has on sight clinicians, 24/7 residential counselors, and the ability to develop programming. The Emergency Services Department staff can provide both day and overnight crisis intervention for multiple persons, which will be beyond the "two bed" capacity of the proposed program.

Though the proposed program can only admit two persons to the unit, it will be able to handle multiple phone triaging, supportive counseling, and even a day time emergency drop in center. The appropriated resources for this project will cover basic staffing requirements and facility costs. Further integrated organizational efforts will allow for enhancing clinical programming and expanding the emergency coverage to include harder to place persons, such as those struggling with substances and adolescents transitioning to adulthood.

1.7 Please provide the proposed admission, discharge and continued stay criteria for the program. Describe how referrals and discharges will be decided consistent with the inpatient diversion and step-down outcomes of the program.

Admission criteria to the proposed crisis stabilization/hospital diversion bed include being a person who is male or female, a Vermont resident, 18 years old or older who is in psychiatric crisis and presenting a danger to her/him-self or others. Specific reasons for admission may be for medication stabilization, emergency need for 24-hour supervision, hospital alternative care and hospital step-down care. Because the program will be voluntary clients must agree to remain in the program, meet with members of the clinical staff, take medication when ordered and mutually agreed upon, and not engage in destructive or assaultive behaviors. People may be excluded, for example, when there is a medical co-morbidity that requires significant medical monitoring, current violent behavior, or lack of ability to self-manage needs such as personal hygiene.

We have reviewed the work being done by the Care Management Group to establish common, standardized definitions for levels of care throughout the larger continuum of care. We intend to utilize the LOCUS or modified LOCUS as encouraged by the Vermont State Hospital Futures subcommittee, Care Management Group, in conjunction with the Level of Change Protocol to maintain consistent descriptive admission and discharge baseline profiles. The LOCUS instrument will be used in conjunction with good clinical judgment to assess immediate service needs, plan for resource utilization, monitor changes in need for levels of care and the determination of placement in the service continuum.

1.8 How will the program be cost effective, including?

a) leveraging resources with existing programs in the network of Designated Agencies and Vermont's hospitals,

The program will be embedded in our Emergency Services Department, which has established designated staff whose sole purpose is to assess and refer clients appropriately. We also intend to coordinate the program with our CRT department, which has knowledge, expertise and an infrastructure that will help to support increased need for staff when necessary as well as additional wrap around services when discharge from the program is imminent.

The Emergency Services Department is in the process of integrating with our Substance Abuse Services Emergency personnel, which enhances the work force's capabilities and allows for the assessing and treatment of co-occurring substance use disorders, including triaging and appropriate placement during crisis. Our Emergency Services Department works in tandem with the local hospital emergency departments to do assessments and where applicable rule out medical co-morbidity. We anticipate that the award of funds to develop a local psychiatric crisis stabilization/hospital diversion program will further enhance this professional relationship, and it will ensure cooperation with regards to the timely medical assessments required for admission to the program. Further, our relationships with other local

agencies (e.g., Kingdom Recovery Center and Community Justice Center) may afford us additional funds and/or workforce to address such issues as transportation and peer supports, which are both necessary components integral to the success of the program.

b) coordinating with existing facilities and programs, and

Our program can only be cost effective if the beds are well utilized, and in time there is a decrease in hospitalizations and inpatient stays. NKHS will actively inform our community partners as well as our sister designated agencies about the availability of the beds, the admitting criteria and referring protocols. This will help to insure the beds are appropriately utilized and provide an on going service to the local and larger communities.

We intend to maintain standard assessment procedures, by using the LOCUS, which will guide our assessments, level of care placement decisions, continued stay criteria and to evaluate clinical outcomes. Since the LOCUS is being considered as a standard assessment tool in the larger system of care in Vermont, we hope that we can work with other systems of care in a coordinated and efficient manner.

c) sharing medical resources

Medical resources in the form of psychiatry services, medication management, and daily health assessment will be the responsibility of the Mental Health Division of NKHS. The allotment of both psychiatry and nursing services will be done by the NKHS's Division of Mental Health Director and the Medical Director in coordination with the CRT and Outpatient Departments. Preadmission medical evaluation will be done at local emergency rooms prior to screening and admission to the program. We also plan to negotiate a memorandum of understanding (MOU) with one of our local health centers that will identify the center as the primary care provider for our program. When medical consultation or non-emergency health care is needed and our client does not have an identified local health care provider the identified health center will provide medical services.

1.9 How will the program secure ongoing input from local program standing committees for program development and policy?

All the members of our standing committees and Board of Directors recognize that the lack of crisis beds in the Northeast Kingdom has greatly affected many people we serve, and it is a gap in services in the system of care. In fact, some standing committee members have been personally affected. At our monthly standing committee meetings, we have asked the committees members for their guidance for this project and we will continue to ask them for their input regularly. The "crisis bed" will be a regular agenda item. All policies and policy changes are reviewed by our standing committees and signed off by our Board of Directors.

Considerations1.10 Additional

In addition to consistency with the program characteristics and principles described above, review criteria for the RFP will also include the following considerations:

a) Proposals that promote geographic access to the following high priority locations in the corridors between White River Junction and north, and between Burlington and Bennington.

NKHS intends to accommodate the regional needs for crisis bed capacity. We have located an appropriate facility and have begun negotiations with the owner about necessary minor structural modifications that need to be put in place. The facility is in close proximity to our new offices in St. Johnsbury, a quarter mile away in a non-residential area on US Route 2

and I-93 spur connecting directly with I-91. This location will allow for easy accessibility for both staff and consumers from our facility and other referring sources in the region. The program location is also close to the Northeastern Vermont Regional Hospital (NVRH), which is about four miles away.

b) Proposals that are prepared to develop a program on an immediate time frame.

We anticipate the start-up of the crisis bed program could be as soon as June 1, 2007. Facility modifications, policy and procedure manuals, job descriptions and some staff recruiting will all take place concurrently.

c) Proposals most successful in leveraging the capacity of existing resources (such as hospitals and other programs that operate 24-7) with these new funds.

The responses to items 1.6 and 1.8a describe the leveraging of existing resources.

d) Proposals from designated agencies that do not have crisis bed programs currently.

The Northeast Kingdom has no community crisis beds, nor does it have any psychiatric hospital beds.

e) Proposals from designated agencies that may have a crisis bed program but that require a second location to assure access within reasonable distances.

Not applicable.

f) Proposals that offer both local and statewide access.

We plan on developing in conjunction with the State a protocol for disseminating information about bed availability to maximize appropriate utilization of the beds both for local people and people from other areas of Vermont. Our program will admit individuals from our neighboring sister agencies according to the Care Management Protocols.

2. Facility Details and Program Costs

2.1 For construction or renovation projects (if applicable):

NKHS intends no capital purchase at this time.

2.2 For projects involving lease arrangements (if applicable):

Given the limitations of funding presented in the RFP our proposal at this time is for two residential beds and program space to accommodate emergency response, coordination with the care coordination network, and services appropriate to the mission of the program. Though we envision that we will probably seek an expansion of the program as future needs dictate and the VSH Futures initiative progresses.

a) Indicate the duration, dates, and terms of the lease.

NKHS intends to accommodate the regional needs for crisis bed capacity and to locate the facility in close proximity of the eastern US Route 2 and Interstate 91 corridors. To this end we are currently reviewing existing sites currently on the market that can meet regional needs. A rental property has been identified that is licensed, equipped with fire alarms, and ideally situated on a US Route 2 and I-93 spur connecting directly with I-91, which is only a 2 mile drive away. If we are awarded the contract we anticipate entering into a flexible lease arrangement. A reasonable expectation for an initial lease arrangement appears to be from three to five years depending on the cost of up front renovations. Since the project is for only a two-bed program, we anticipate initial renovation will be minimal and the cost is accounted for in our rent estimate. If an agreement is reached building occupancy will take only a

matter of weeks and the start of operations will mainly be subject to the availability staff and program development.

b) Compare costs of lease with purchase option.

The operating costs for the rental of space for a two bed facility are included in the attached budget. Recent construction projects at NKHS (e.g., Kingdom Way Group Home) show construction of accessible residential housing to be at a minimum $160 per square foot and can exceed $200 per square foot not including land, interest and depreciation costs. By utilizing an already existing structure available in the rental market the cost and time needed for constructing a building will be eliminated. If there is a future need for more than two beds the flexible lease is clearly the most economical alternative.

2.3 For projects involving the refinancing of existing debt (if applicable):

NKHS will not have to refinance any existing debt to be able to provide the planned crisis beds.

3. Local Governance Support and Relationship of Proposed Project to Agency Strategic Plan: COA Criterion 1

3.1 Please provide information about how this proposal was reviewed and approved by the applicant's Board of Directors and the appropriate Local Standing Committee or Committees.

The NKHS Board of Directors has been advised of the developments of the VSH Futures project since its inception and has endorsed the submission of our response to the RFP. Our Board has been supportive of any reasonable efforts to assist in the VSH Futures Project. At the February 6, 2007 monthly board meeting, the board of directors passed a resolution to support the NKHS administration's response, by a unanimous vote, to the RFP and establishment of a crisis bed program.

The lack of crisis beds and hospital diversion opportunities has been a concern for our standing committees both from a personal perspective as well as recognizing community need. The current proposal for the crisis beds represented in this RFP were presented at the February meeting of both our adult mental health and substance abuse standing committees. The members have reviewed all aspects of the plan in detail, and they have given their unanimous approval for proceeding.

3.2 Please describe how this proposal is consistent with your agency's Strategic Plan or System of Care Plans. Please describe any public input or involvement that your agency has participated in or invited as part of the development of this proposal.

Northeast Kingdom Human Services has been in the process of developing a new strategic plan that addresses our commitment to provide holistic human services in a caring empathic welcoming environment regardless of the nature of the complex issues our clients present. To fulfill this mission we have begun a process of reorganizing our departments to maximize their effectiveness and responsiveness to the growing community needs. We have integrated our Mental Health and Substance Abuse Departments from an administrative perspective, further integrated the departments with combined clinical teams, and we have also begun the process of co-locating these previously separate departments under one roof.

Another part of the overall strategic plan has been the development of a separate and dedicated Emergency Services Department. This will allow for faster more responsive emergency assessments with the capability to manage psychiatric and addictive co-

morbidity. The Emergency Services Department also will facilitate the development of the crisis/diversion program that will offer another level of care previously missing in our local system of care. There will be a greater positive impact on the clients we serve both from the perspective of those in crisis, (the ability to be more responsive) and those not in crisis, (previously on-call clinicians may have had to cancel appointments or leave appointments to address the acute needs of other clients).

The lack of psychiatric beds, in-patient and/or crisis beds, is of great concern to our community partners. Our dedicated involvement in other opportunities to bring sub-acute psychiatric services to this region has been well publicized, advertised and communicated through various public forums. Through our Community Coordinating Council partnerships both in Newport and St. Johnsbury, our District Leadership Team, St. Johnsbury Health Advisory Board, Primary Care/Behavioral Health Partnership, and the Public Inebriate Program that meet regularly and include participation from multiple stakeholders (e.g., state and local law enforcement, hospital personnel, Department of Corrections, Probation and Parole, clergy, and importantly our AHS field directors), we have had the opportunity to receive and give information and discuss program design, location, transportation, funding and staffing challenges. Though this RFP was only offered January 8, 2007, we at NKHS have been planning for the development of crisis beds with our community partners for the last two years.

3.3 If the proposal involves any new or reorganized services, describe how they will be coordinated with other services or providers in your area?

As outlined in section 3.2, the program will be imbedded in a newly designed, but long standing NKHS Emergency Services Department. Prior to our reorganization, emergency services were imbedded in the Outpatient Department, dependent upon our outpatient clinical team to provide emergency coverage during the day. This has been a disruptive arrangement for scheduled patients as well as for the clinicians. This disruption can affect consumer satisfaction as well as access to services. We currently have two designated daytime emergency mental health clinicians and have back-up provided by assigned clinicians. After-hours calls are handled by a volunteer QMHP clinical rooster (volunteer meaning not required). They are supervised by the emergency clinician team leader. The newly organized department has a director, a clinical team, which consists of both mental health and substance abuse staff. There is also a cadre of workers who provide transport, respite and direct non-clinical supervision to assigned clients. Support and consultation is available from our psychiatry medical staff. Upon receipt of the award we will further develop the Emergency Services Department and locate a portion of the department at the crisis bed program site where staff will provide administrative and clinical oversight to the crisis bed program. Further, scheduling for psychiatric services, nursing oversight, outreach, peer support services, and case management will be provided through coordination with both the CRT Department and Outpatient Services.

4. Need for the Proposed Project: COA Criterion II

4.1 Please describe how this proposal is consistent with Vermont's Health Resource Allocation Plan (H-RAP).

Our proposed multi-functional crisis/hospital diversion two bed program parallels the standards specified in the Health Resource Allocation Plan. We intend to provide short term psychiatric care and emergency psychiatric care in as responsive and engaging manner as

possible. As stated in our Letter of Intent our intention of this proposal is to provide triage and observation, crisis stabilization, hospital alternatives, and hospital step down care. You will find those objectives outlined throughout this proposal. Feedback from many consumers have revealed intense dissatisfaction with the current process of arduous hours languishing in emergency rooms, subjected to the stigmata of those unfamiliar with the disease of mental illness, while waiting for hospital placement somewhere in the state. Even when a placement is established more hours pass as transportation arrangements are attempted to be made. This program affords us the capability to be as responsiveness as possible in the early hours of a psychiatric crisis with disposition options available to consumers in an immediate timeframe. Many processes will be influenced by this, for example, emergency rooms will be more apt to prioritize patients in psychiatric crisis, patients themselves will be positively effected having supportive supervised clinical options close to home to help them through their crisis, and the larger system of care will have reduced pressure on their inpatient systems.

4.2 As this project is in response to a Request for Proposals, it is not necessary to demonstrate need for new crisis stabilization / diversion beds. Instead, please describe how the program will meet the primary outcomes of reducing and diverting psychiatric inpatient use. What specific targets, from the outcomes listed below, will the program meet?

a) Reduce inpatient psychiatric admissions to VSH and General Hospitals Reduce the number of inpatient days at VSH and General Hospitals

After diligent review of the inpatient hospitalization data from a variety of resources and clinical anecdotal discussions regarding placement options if alternative programming for our CRT clients could have existed, it appears that with the option of hospital diversion 90% our CRT admissions may have been avoided. Clearly 10% or rather approximately 7 out of the 70 hospital admissions were appropriate placements. The other admissions required a level of care that did not exist and there for needed the next available level of care, that being hospitalization. This determination was made from the data provided by the CRT Client Admissions and Bed Days at General Hospitals report. In comparison, the report submitted by the Crisis Bed Development work Group, showed 29 inpatient hospitalizations of CRT clients in a six month period, 19 of whom could have been diverted from hospitalization if a crisis diversion bed was available. This shows a possible 65% hospital diversion rate. It is projected that length of stay during psychiatric hospitalization could be reduced by as many as 400 days a year. The outpatient figure in the same report suggests a 52% hospital diversion rate for non CRT clients if an alternative program existed. With this in mind, we are eager to work with the department to target an achievable outcome in the 30 to 50 percent range, once we are fully operational, in decreasing psychiatric admissions and reducing bed days. We would like to anticipate full utilization of our program and for the greater continuum of care, influence positive change in lower admissions and decreases in length of stay.

b) Please describe the methodology and data employed to develop these outcome targets.

The identified targeted objects were established after careful consideration of several sources. First we reviewed client records of hospitalized patients, including precursory events leading up to the admission as well as length of stay and limits to early discharge. We reviewed data

from the monthly VSH Census Report, data from the annual report of CRT Client Admissions and Bed Days at General Hospitals developed by the Department of Mental Health's Acute Care Team, and the data from the survey developed by and included in the Crisis Bed Development Work Group report. Consultation with directors and program coordinators in both the CRT program and ES/AO program was also sought.

4.3 Describe how service utilization and program effectiveness will be reviewed?

Daily tracking of service utilization will be the responsibility of the Crisis Bed Program director. These will include maintaining reports of bed census, availability, length of stays, referral sources, levels of care upon discharge (both to a higher or lower level of care) and aftercare outreach efforts. Daily clinical rounds will determine patient's readiness for discharge and or increased levels of care such as admission to an acute psychiatric hospital unit. Consumer feedback on program effectiveness will be solicited through satisfaction surveys and input from our community providers and those in the larger system of care will also be sought. This program will be included in our existing quality review, peer review and incident review process.

5. Organizational Structure, Affiliations and Operations: COA Criterion III

5.1 The entity making this application / proposal must be a Vermont Mental Health and/or Developmental Services Designated or Specialized Service Agency.

Northeast Kingdom Human Service is a 501(c)3 not for profit corporation and has been designated by the State of Vermont to provide services to Adults with severe and persistent mental illness and operates the CRT programs in three counties, Orleans, Essex and Caledonia. In addition we are designated to provide services to Children with severe mental illness and the developmentally disabled. We are the area provider for crisis services and for substance abuse services and as a community provider provide a broad base of infrastructure that will assist the development and success of new programs.

5.2 (if applicable) If the applicant is not a single designated agency but rather a consortium of agencies or if the designated agency applicant intends to subcontract for the service:

a) Please provide details about the organization's governance, organizational structure and

Not Applicable

b) Plans for consumer involvement in governing the entity.

As stated in sections 1.9 and 3.1, we have and will continue to solicit direct feedback from our local standing committees regarding programming, design, and consumer satisfaction. Our Board of Directors consists of 60% consumers or family members of consumers and is the ultimate governing entity of all our operations.

c) Please describe any key organizational arrangements necessary to implement this proposal such as contracts, affiliations, or partnerships and the financial or other contributions that any affiliated organization or related party will be making to the project.

NKHS will have sole responsibility for the program operation, staffing, and all program components. Though it is possible based on our normal operational practice that some number of professional services such as nursing on a per diem basis, personnel to do evaluations, etc. would have to be contracted from outside sources for this program during the recruitment phase. We will be seeking memorandums of understanding (MOU) with our regional hospitals to secure timely processing whenever possible for patients in need of

psychiatric emergency treatment to gain medical clearance to facilitate appropriate admissions to our program. Additional MOUs will be obtained from other agencies such as the Kingdom Recovery Center for agreements regarding cadre, transportation stipends, and other supportive resources.

6. Financial Feasibility and Impact Analysis: COA Criterion IV

6.1 Please describe how the project will provide maximum service capacity within available resources.

In addition to submitting the attached financial tables, please provide any narrative information that you believe would help illustrate the financial impact and feasibility of this project. If the tables reflect anything significant that requires an explanation or clarity, please address this in the narrative.

In reviewing the financial tables please note the following information:

- As stated before, this project will require no capital investment and therefore those tables relating to this are not applicable and not included. Tables begin with 3A.
- The budget submitted for the program is submitted as an annual operations budget. We realize that only partial funding for the project for the first half year is available as stated on page 2 of the RFP. Given that start-up dates are yet to be defined, we used the annual budget numbers to better determine daily rates and it is customary to view programs in an annual perspective in our proposals to the Division of Mental Health.
- Regarding the spreadsheets dealing with projections into future years for the total agency, please note that the major changes in the projections and the balance sheets over time are due to new buildings currently in the final stages of construction that are coming on line in April 2007. The significant expenses for these buildings will be realized this spring and carried through to future years. These costs are not related to this proposed crisis bed program.

6.2 Were any alternatives to this proposal considered and, if so, why were they rejected? Explain why you believe there is no other less costly or more effective alternatives to be considered.

This project has been under strong consideration for the past two years and was originally conceived in the context of our proposed design for the VSH Futures sub-acute rehabilitation center. All of our proposals have included and will continue to include direct dialogues with our community hospitals in an effort to institute a crisis bed on the campus of our local medical centers. This remains a necessity for those patients who are medically compromised to the extent that their medical treatments are beyond the scope of our capabilities. Many clients would benefit from close proximity to advanced medical interventions. We understand that currently there is no available space on the campuses of Northeastern Vermont Regional Hospital or North Country Hospital to include a unit of this kind. However, the possibility of new construction on either campus remains a topic of continuous discussion. Because there is an immediate need, we have chosen to develop the crisis bed program independently from our medical partners, but with MOUs to work with us around issues of medical clearance and co-morbidity issues.

We have made every effort to combine our resources with community ancillary services to produce an effective, responsive and inclusive program for the two bed unit. We anticipate the need for adaptation to additional community needs. For example, public inebriates, transitional age youth and children in crisis who need short term respite. Law prohibits combining adult and child residential programming but the design of the facility allow for creative programming and staffing to maximize utilization when availability permits.

6.3 Please address any of the following that are applicable to your proposed project:

a) For projects that require high levels of debt financing relative to the cash flow of the institution, please submit the previous year's balance sheet and a projected balance sheet reflecting the increased debt level.

This project as presented requires no level of debt financing. Financial exposure is limited to the rent agreement with a private party. We are generally aware of the lease terms of similar property arrangements and see a small two-bed rental as not presenting any unacceptable risk. The budget submitted for the total program represents approximately 1.5% of our total operational budget.

b) For projects whose financial feasibility is endangered by low utilization, submit a financial forecast in which utilization levels are only sufficient for the service to break even financially.

Given the small number of beds, the multi use functional capabilities of the program and the identified community need for alternative options to out of area hospitalizations for both our catchment area and our neighboring centers, we forecast high utilization. Once the funding mechanisms are identified, rates can be projected based on a percentage of occupancy agreed upon with the State.

6.4 **Financial Tables**

Please complete the following financial tables which are included in Excel format.

Table	Description
1	Project Costs *(Not Applicable – No capital construction is included in this submission.)*
2	Debt Financing Arrangement: Sources & Uses of funds (Not Applicable – *No debt financing is included in this submission.)*
3A	Income Statement: Without Project
3B	Income Statement: Project Only
3C	Income Statement: With Project
4A	Balance Sheet-Unrestricted Funds: Without Project
4B	Balance Sheet-Unrestricted Funds: Project Only
4C	Balance Sheet-Unrestricted Funds: With Project
5A	Statement of Cash Flows: Without Project
5B	Statement of Cash Flows: Project Only
5C	Statement of Cash Flows: With Project

Table 3A, Income Statement: Without Project

NKHS, INC.
CERTIFICATE OF APPROVAL APPLICATION TABLES
TABLE 3A
INCOME STATEMENT
WITHOUT PROJECT

	Latest Actual 2006	Budget 2007	Proposed Year 1 2008	Proposed Year 2 2009	Proposed Year 3 2010
Revenues					
First Party	235,176	206,662	214,928	219,227	223,612
Other Insurance	342,202	267,641	278,347	283,914	289,592
Medicaid	3,433,229	3,983,656	4,143,002	4,225,862	4,310,379
Managed Medicaid (Incl. VHAP, PC Plus)	405,800	327,169	327,169	327,169	327,169
CRT Case Rate	2,737,767	2,784,100	2,895,464	2,953,373	3,012,440
Waiver	11,901,790	12,492,512	12,992,212	13,252,056	13,517,097
PNMI	-	-	-	-	-
Other Fee For Service	594,236	542,403	542,403	542,403	542,403
Federal Grants	-	-	-	-	-
Other State	1,411,582	1,339,093	1,339,093	1,339,093	1,339,093
DDMHS Grants	1,113,739	1,056,833	1,056,833	1,056,833	1,056,833
Local/Other	155,907	130,964	130,964	130,964	130,964
Total Revenues	**22,331,428**	**23,131,033**	**23,920,415**	**24,330,894**	**24,749,582**
Expenses					
Salaries	9,968,112	10,657,951	11,084,269	11,305,954	11,532,073
Salaries for Respite Workers	-	-	-	-	-
Clinical Contractual	-	-	-	-	-
Contracted Respite Workers	-	-	-	-	-
Fringe	3,744,239	4,076,954	4,163,492	4,246,761	4,331,697
Contractual Services	5,311,187	5,312,512	5,312,512	5,312,512	5,312,512
General Operating	912,520	927,153	927,153	927,153	927,153
ICF Tax	-	-	-	-	-
Program	471,546	466,447	466,447	466,447	466,447
VSH Bed Assessment	-	-	-	-	-
Travel/Transport	839,357	888,656	888,656	888,656	888,656
Building - Direct	386,065	542,815	912,874	978,356	1,043,728
Other Non-Operating	-	-	-	-	-
Transportation (Allocated)	-	-	-	-	-
Building - (Indirect Allocated)	-	-	-	-	-
Admin I (Allocated)	-	-	-	-	-
Admin II (Allocated)	-	-	-	-	-
Fringe (Allocated)	-	-	-	-	-
Total Expense	**21,633,026**	**22,872,488**	**23,755,403**	**24,125,839**	**24,502,266**
Net Operating Income (Loss)	**698,402**	**258,545**	**165,012**	**205,055**	**247,316**
Non-Operating Revenue	-	-	-	-	-
Excess (Deficit) of Rev Over Exp	**698,402**	**258,545**	**165,012**	**205,055**	**247,316**

Table 3B, Income Statement: Project Only

NKHS, INC.
CERTIFICATE OF APPROVAL APPLICATION TABLES
TABLE 3B
INCOME STATEMENT
PROJECT ONLY

	Latest Actual 2006	NKHS Crisis Bed Proposal 2007	Proposed Year 1 2008	Proposed Year 2 2009	Proposed Year 3 2010
Revenues					
First Party		-	-	-	-
Other Insurance		-	-	-	-
Medicaid		-	-	-	-
Managed Medicaid (Incl. VHAP, PC Plus)		-	-	-	-
CRT Case Rate		-	-	-	-
Waiver		-	-	-	-
PNMI		-	-	-	-
Other Fee For Service		-	-	-	-
Federal Grants		-	-	-	-
Other State		-	-	-	-
DDMHS Grants		365,210	392,700	406,600	418,500
Local/Other		-	-	-	-
Total Revenues		365,210	392,700	406,600	418,500
Expense					
Salaries		189,000	196,600	200,500	204,500
Salaries for Respite Workers		-	-	-	-
Clinical Contractual		-	-	-	-
Contracted Respite Workers		-	-	-	-
Fringe		64,260	73,800	76,700	76,800
Contractual Services		-	-	-	-
General Operating		3,000	3,000	3,000	3,000
ICF Tax		-	-	-	-
Program		10,000	10,000	10,000	10,000
VSH Bed Assessment		-	-	-	-
Travel/Transport		11,500	11,500	11,500	11,500
Building - Direct		43,200	48,600	54,700	61,500
Other Non-Operating		-	-	-	-
Transportation (Allocated)		-	-	-	-
Building - (Indirect Allocated)		-	-	-	-
Admin I (Allocated) - agency		26,550	29,500	30,100	30,700
Admin II (Allocated) - program		17,700	19,700	20,100	20,500
Fringe (Allocated)			-	-	-
Total Expense		365,210	392,700	406,600	418,500
Net Operating Income (Loss)		-	-	-	-
Non-Operating Revenue		-	-	-	-
Excess (Deficit) of Rev Over Exp		-	-	-	-

Table 3C, Income Statement: With Project

NKHS, INC.
CERTIFICATE OF APPROVAL APPLICATION TABLES
TABLE 3C
INCOME STATEMENT
WITH PROJECT

	Latest Actual 2006	NKHS Crisis Bed Proposal/ Budget 2007	Proposed Year 1 2008	Proposed Year 2 2009	Proposed Year 3 2010
Revenues					
First Party	235,176	206,662	214,928	219,227	223,612
Other Insurance	342,202	267,641	278,347	283,914	289,592
Medicaid	3,433,229	3,983,656	4,143,002	4,225,862	4,310,379
Managed Medicaid (Incl. VHAP, PC Plus)	405,800	327,169	327,169	327,169	327,169
CRT Case Rate	2,737,767	2,784,100	2,895,464	2,953,373	3,012,440
Waiver	11,901,790	12,492,512	12,992,212	13,252,056	13,517,097
PNMI	-	-	-	-	-
Other Fee For Service	594,236	542,403	542,403	542,403	542,403
Federal Grants	-	-	-	-	-
Other State	1,411,582	1,339,093	1,339,093	1,339,093	1,339,093
DDMHS Grants	1,113,739	1,422,043	1,449,533	1,463,433	1,475,333
Local/Other	155,907	130,964	130,964	130,964	130,964
Total Revenues	22,331,428	23,496,243	24,313,115	24,737,494	25,168,082
Expense					
Salaries	9,968,112	10,846,951	11,280,869	11,506,454	11,736,573
Salaries for Respite Workers	-	-	-	-	-
Clinical Contractual	-	-	-	-	-
Contracted Respite Workers	-	-	-	-	-
Fringe	3,744,239	4,141,214	4,237,292	4,323,461	4,408,497
Contractual Services	5,311,187	5,312,512	5,312,512	5,312,512	5,312,512
General Operating	912,520	930,153	930,153	930,153	930,153
ICF Tax	-	-	-	-	-
Program	471,546	476,447	476,447	476,447	476,447
VSH Bed Assessment	-	-	-	-	-
Travel/Transport	839,357	900,156	900,156	900,156	900,156
Building - Direct	386,065	586,015	961,474	1,033,056	1,105,228
Other Non-Operating	-	-	-	-	-
Transportation (Allocated)	-	-	-	-	-
Building - (Indirect Allocated)	-	-	-	-	-
Admin I (Allocated)	-	26,550	29,500	30,100	30,700
Admin II (Allocated)	-	17,700	19,700	20,100	20,500
Fringe (Allocated)	-	-	-	-	-
Total Expense	21,633,026	23,237,698	24,148,103	24,532,439	24,920,766
Net Operating Income (Loss)	698,402	258,545	165,012	205,055	247,316
Non-Operating Revenue	-	-	-	-	-
Excess (Deficit) of Rev Over Exp	698,402	258,545	165,012	205,055	247,316

Table 4A, Balance Sheet-Unrestricted Funds: Without Project

NKHS, INC.
CERTIFICATE OF APPROVAL APPLICATION TABLES
TABLE 4A
BALANCE SHEET - UNRESTRICTED FUNDS
WITHOUT PROJECT

ASSETS	Latest Actual 2006	Budget 2007	Proposed Year 1 2008	Proposed Year 2 2009	Proposed Year 3 2010
Assets - Current					
Cash	2,157,157	2,049,620	2,359,205	2,728,591	3,134,701
A/R Patient/Medicaid Fees	1,090,271	1,126,773	1,171,844	1,195,281	1,219,187
A/R Other Non-Medicaid Fees	139,355	162,667	169,174	172,557	176,008
A/R Other State Grants/Contracts	142,556	121,013	121,013	121,013	121,013
A/R Local & Other	46,352	62,495	62,495	62,495	62,495
Other Current Assets	122,993	472,175	472,175	472,175	472,175
SUM:	3,698,684	3,994,743	4,355,906	4,752,112	5,185,579
Assets - Fixed					
Land	352,109	276,629	276,629	276,629	276,629
Buildings	1,204,611	5,124,120	5,124,120	5,124,120	5,124,120
Furnishing & Equipment	1,169,657	1,158,589	1,158,589	1,158,589	1,158,589
Vehicles	159,000	180,323	180,323	180,323	180,323
Accumulated Depr - Buildings	(975,994)	(1,156,212)	(1,432,363)	(1,708,514)	(1,984,665)
Accumulated Depr - Furnishings	(1,070,070)	(1,123,118)	(1,123,118)	(1,123,118)	(1,123,118)
Accumulated Depr - Vehicles	(85,013)	(145,626)	(145,626)	(145,626)	(145,626)
Other Fixed Assets & BDF	2,895,655	1,632,412	1,632,412	1,632,412	1,632,412
SUM:	3,649,955	5,947,117	5,670,966	5,394,815	5,118,664
Assets - Total	**7,348,639**	**9,941,860**	**10,026,872**	**10,146,927**	**10,304,243**
Liabilities - Current					
Accounts payable & other current liab.	2,872,109	2,622,333	2,622,333	2,622,333	2,622,333
Deferred Inc - DDMHS Grants/Contracts	76,843	139,799	139,799	139,799	139,799
Deferred Inc - Other State Contracts	42,060	7,225	7,225	7,225	7,225
Deferred Inc - Local	767	872	872	872	872
SUM:	2,991,779	2,770,229	2,770,229	2,770,229	2,770,229
Liabilities - Long Term					
Vehicle/Equipment Loans	-	-	-	-	-
Mortgage	-	2,932,464	2,852,464	2,767,464	2,677,464
Other Long-Term Liabilities	-	-	-	-	-
SUM:	-	2,932,464	2,852,464	2,767,464	2,677,464
Liabilities - Total	2,991,779	5,702,693	5,622,693	5,537,693	5,447,693
Liabilities - Fund Balance					
Operating Fund Balance	3,658,458	3,980,622	4,239,167	4,404,179	4,609,234
Current Net Gain/(Loss)	698,402	258,545	165,012	205,055	247,316
Liabilities & Fund Balance - Total	**7,348,639**	**9,941,860**	**10,026,872**	**10,146,927**	**10,304,243**

Table 4B, Balance Sheet-Unrestricted Funds: Project Only

NKHS, INC.
CERTIFICATE OF APPROVAL APPLICATION TABLES
TABLE 4B
BALANCE SHEET - UNRESTRICTED FUNDS
PROJECT ONLY

ASSETS	Latest Actual 2006	NKHS Crisis Bed Proposal 2007	Proposed Year 1 2008	Proposed Year 2 2009	Proposed Year 3 2010
Assets - Current					
Cash		(91,303)	(98,175)	(101,650)	(104,625)
A/R Patient/Medicaid Fees		-	-	-	-
A/R Other Non-Medicaid Fees		-	-	-	-
A/R Other State Grants/Contracts		91,303	98,175	101,650	104,625
A/R Local & Other		-	-	-	-
Other Current Assets		-	-	-	-
SUM:		-	-	-	-
Assets - Fixed					
Land		-	-	-	-
Buildings		-	-	-	-
Furnishing & Equipment		-	-	-	-
Vehicles		-	-	-	-
Accumulated Depr - Buildings		-	-	-	-
Accumulated Depr - Furnishings		-	-	-	-
Accumulated Depr - Vehicles		-	-	-	-
Other Fixed Assets & BDF		-	-	-	-
SUM:		-	-	-	-
Assets - Total		-	-	-	-
Liabilities - Current					
Accounts payable & other current liab.		-	-	-	-
Deferred Inc - DDMHS Grants/Contracts		-	-	-	-
Deferred Inc - Other State Contracts		-	-	-	-
Deferred Inc - Local		-	-	-	-
SUM:		-	-	-	-
Liabilities - Long Term					
Vehicle/Equipment Loans		-	-	-	-
Mortgage		-	-	-	-
Other Long-Term Liabilities		-	-	-	-
SUM:		-	-	-	-
Liabilities - Total		-	-	-	-
Liabilities - Fund Balance					
Operating Fund Balance		-	-	-	-
Current Net Gain/(Loss)		-	-	-	-
Liabilities & Fund Balance - Total		-	-	-	-

Table 4C, Balance Sheet-Unrestricted Funds: With Project

NKHS, INC.
CERTIFICATE OF APPROVAL APPLICATION TABLES
TABLE 4C
BALANCE SHEET - UNRESTRICTED FUNDS
WITH PROJECT

ASSETS	Latest Actual 2006	NKHS Crisis Bed Proposal/ Budget 2007	Proposed Year 1 2008	Proposed Year 2 2009	Proposed Year 3 2010
Assets - Current					
Cash	2,157,157	1,958,317	2,261,030	2,626,941	3,030,076
A/R Patient/Medicaid Fees	1,090,271	1,126,773	1,171,844	1,195,281	1,219,187
A/R Other Non-Medicaid Fees	139,355	162,667	169,174	172,557	176,008
A/R Other State Grants/Contracts	142,556	212,316	219,188	222,663	225,638
A/R Local & Other	46,352	62,495	62,495	62,495	62,495
Other Current Assets	122,993	472,175	472,175	472,175	472,175
SUM:	3,698,684	3,994,743	4,355,906	4,752,112	5,185,579
Assets - Fixed					
Land	352,109	276,629	276,629	276,629	276,629
Buildings	1,204,611	5,124,120	5,124,120	5,124,120	5,124,120
Furnishing & Equipment	1,169,657	1,158,589	1,158,589	1,158,589	1,158,589
Vehicles	159,000	180,323	180,323	180,323	180,323
Accumulated Depr - Buildings	(975,994)	(1,156,212)	(1,432,363)	(1,708,514)	(1,984,665)
Accumulated Depr - Furnishings	(1,070,070)	(1,123,118)	(1,123,118)	(1,123,118)	(1,123,118)
Accumulated Depr - Vehicles	(85,013)	(145,626)	(145,626)	(145,626)	(145,626)
Other Fixed Assets & BDF	2,895,655	1,632,412	1,632,412	1,632,412	1,632,412
SUM:	3,649,955	5,947,117	5,670,966	5,394,815	5,118,664
Assets - Total	7,348,639	9,941,860	10,026,872	10,146,927	10,304,243
Liabilities - Current					
Accounts payable & other current liab.	2,872,109	2,622,333	2,622,333	2,622,333	2,622,333
Deferred Inc - DDMHS Grants/Contracts	76,843	139,799	139,799	139,799	139,799
Deferred Inc - Other State Contracts	42,060	7,225	7,225	7,225	7,225
Deferred Inc - Local	767	872	872	872	872
SUM:	2,991,779	2,770,229	2,770,229	2,770,229	2,770,229
Liabilities - Long Term					
Vehicle/Equipment Loans	-	-	-	-	-
Mortgage	-	2,932,464	2,852,464	2,767,464	2,677,464
Other Long-Term Liabilities	-	-	-	-	-
SUM:	-	2,932,464	2,852,464	2,767,464	2,677,464
Liabilities - Total	2,991,779	5,702,693	5,622,693	5,537,693	5,447,693
Liabilities - Fund Balance					
Operating Fund Balance	3,658,458	3,980,622	4,239,167	4,404,179	4,609,234
Current Net Gain/(Loss)	698,402	258,545	165,012	205,055	247,316
Liabilities & Fund Balance - Total	7,348,639	9,941,860	10,026,872	10,146,927	10,304,243

Table 5A, Statement of Cash Flows: Without Project

NKHS, INC.
CERTIFICATE OF APPROVAL APPLICATION TABLES
TABLE 5A
STATEMENT OF CASH FLOWS
WITHOUT PROJECT

	Latest Actual 2006	Budget 2007	Proposed Year 1 2008	Proposed Year 2 2009	Proposed Year 3 2010
CASH FLOWS FROM OPERATING ACTIVITIES					
Change in Net Assets	698,402	**258,545**	**165,012**	**205,055**	**247,316**
Adjustments to reconcile changes in					
net assets to net cash provided					
Depreciation	147,203	266,037	276,151	276,151	276,151
Gain from sale of property and equipment	(250)	-	-	-	-
(Increase)/Decrease in:					
Other Receivables	247,545	5,400	-	-	-
Accounts Receivable	190,994	(59,814)	(51,578)	(26,820)	(27,357)
Other Current Assets	156,581	(349,182)	-	-	-
Board-designated funds	269,926	563,662	-	-	-
Capital Campaign Pledges Receivable	-	-	-	-	-
Increase/(Decrease) in:					
Accrued Vacation	-	-	-	-	-
Accounts Payable & other current liab.	539,137	(300,789)	-	-	-
Accrued Benefits & Salaries	-	-	-	-	-
Other Obligations	-	-	-	-	-
Deferred Revenue	245,907	28,226	-	-	-
NET CASH PROVIDED BY OPERATING ACTIVITIES	2,495,445	412,085	389,585	454,386	496,110
CASH FLOWS FROM INVESTING ACTIVITIES					
Purchase of Property, Plant, & Equipment	(1,509,104)	(3,503,097)	-	-	-
Bond Issue Costs	-	-	-	-	-
Net Increase in Investments	-	-	-	-	-
NET CASH USED BY INVESTING ACTIVITIES	**(1,509,104)**	**(3,503,097)**	**-**	**-**	**-**
CASH FLOWS FROM FINANCING ACTIVITIES					
Proceeds from Long-Term Debt	250	3,000,000	-	-	-
Payment of Long-Term Debt	-	(16,525)	(80,000)	(85,000)	(90,000)
NET CASH PROVIDED BY FINANCING ACTIVITIES	250	2,983,475	(80,000)	(85,000)	(90,000)
NET INCREASE/(DECREASE) IN CASH	986,591	**(107,537)**	**309,585**	**369,386**	**406,110**
CASH, Beginning of Year	1,170,566	2,157,157	2,049,620	2,359,205	2,728,591
CASH, End of Year	2,157,157	2,049,620	2,359,205	2,728,591	3,134,701

Table 5B, Statement of Cash Flows: Project Only

NKHS, INC.
CERTIFICATE OF APPROVAL APPLICATION TABLES
TABLE 5B
STATEMENT OF CASH FLOWS
PROJECT ONLY

	Latest Actual 2006	NKHS Crisis Bed Proposal 2007	Proposed Year 1 2008	Proposed Year 2 2009	Proposed Year 3 2010
CASH FLOWS FROM OPERATING ACTIVITIES					
Change in Net Assets		-	-	-	-
Adjustments to reconcile changes in net assets to net cash provided					
Depreciation		-	-	-	-
Amortization		-	-	-	-
(Increase)/Decrease in:					
Other Receivables		(91,303)	(6,872)	(3,475)	(2,975)
Accounts Receivable		-	-	-	-
Other Current Assets		-	-	-	-
Board-designated funds		-	-	-	-
Capital Campaign Pledges Receivable		-	-	-	-
Increase/(Decrease) in:					
Accrued Vacation		-	-	-	-
Accounts Payable & other current liab.		-	-	-	-
Accrued Benefits & Salaries		-	-	-	-
Other Obligations		-	-	-	-
Deferred Revenue		-	-	-	-
NET CASH PROVIDED BY OPERATING ACTIVITIES		(91,303)	(6,872)	(3,475)	(2,975)
CASH FLOWS FROM INVESTING ACTIVITIES					
Purchase of Property, Plant, & Equipment		-	-	-	-
Bond Issue Costs		-	-	-	-
Net Increase in Investments		-	-	-	-
NET CASH USED BY INVESTING ACTIVITIES		-	-	-	-
CASH FLOWS FROM FINANCING ACTIVITIES					
Proceeds from Long-Term Debt		-	-	-	-
Payment of Long-Term Debt		-	-	-	-
NET CASH PROVIDED BY FINANCING ACTIVITIES		-	-	-	-
NET INCREASE/(DECREASE) IN CASH		**(91,303)**	**(6,872)**	**(3,475)**	**(2,975)**
CASH, Beginning of Year		-	(91,303)	(98,175)	(101,650)
CASH, End of Year		(91,303)	(98,175)	(101,650)	(104,625)

Table 5C, Statement of Cash Flows: With Project

NKHS, INC.
CERTIFICATE OF APPROVAL APPLICATION TABLES
TABLE 5C
STATEMENT OF CASH FLOWS
WITH PROJECT

	Latest Actual 2006	NKHS Crisis Bed Proposal/ Budget 2007	Proposed Year 1 2008	Proposed Year 2 2009	Proposed Year 3 2010
CASH FLOWS FROM OPERATING ACTIVITIES					
Change in Net Assets	698,402	258,545	165,012	205,055	247,316
Adjustments to reconcile changes in					
net assets to net cash provided					
Depreciation	147,203	266,037	276,151	276,151	276,151
Amortization	(250)	-	-	-	-
(Increase)/Decrease in:					
Other Receivables	247,545	(85,903)	(6,872)	(3,475)	(2,975)
Accounts Receivable	190,994	(59,814)	(51,578)	(26,820)	(27,357)
Other Current Assets	156,581	(349,182)	-	-	-
Board-designated funds	269,926	563,662	-	-	-
Capital Campaign Pledges Receivable	-	-	-	-	-
Increase/(Decrease) in:					
Accrued Vacation	-	-	-	-	-
Accounts Payable & other current liab.	539,137	(300,789)	-	-	-
Accrued Benefits & Salaries	-	-	-	-	-
Other Obligations	-	-	-	-	-
Deferred Revenue	245,907	28,226	-	-	-
NET CASH PROVIDED BY OPERATING ACTIVITIES	2,495,445	320,782	382,713	450,911	493,135
CASH FLOWS FROM INVESTING ACTIVITIES					
Purchase of Property, Plant, & Equipment	(1,509,104)	(3,503,097)	-	-	-
Bond Issue Costs	-	-	-	-	-
Net Increase in Investments	-	-	-	-	-
NET CASH USED BY INVESTING ACTIVITIES	**(1,509,104)**	**(3,503,097)**	**-**	**-**	**-**
CASH FLOWS FROM FINANCING ACTIVITIES					
Proceeds from Long-Term Debt	250	3,000,000	-	-	-
Payment of Long-Term Debt	-	(16,525)	(80,000)	(85,000)	(90,000)
NET CASH PROVIDED BY FINANCING ACTIVITIES	250	2,983,475	(80,000)	(85,000)	(90,000)
NET INCREASE/(DECREASE) IN CASH	986,591	(198,840)	302,713	365,911	403,135
CASH, Beginning of Year	1,170,566	2,157,157	1,958,317	2,261,030	2,626,941
CASH, End of Year	2,157,157	1,958,317	2,261,030	2,626,941	3,030,076